Mountaineer Flexible Benefits Plan

2009

Public Employees Insurance Agency

REFERENCE GUIDE

Office of the Governor
State Capitol
1900 Kanawha Boulevard, E.
Charleston, WV 25305

State of West Virginia
Joe Manchin III
Governor

Dear Public Employee:

It is time again to enroll in the Mountaineer Flexible Benefits Plan. This program is provided to you by the Public Employees Insurance Agency (PEIA).

The program features Flexible Spending Accounts, dental, vision and short-term and long-term disability insurances. We are pleased to announce improvements in the dental plan. These benefits will become effective on July 1, 2008, and continue through June 30, 2009.

I encourage you to attend one of the PEIA Benefit Fairs in your area to learn more about your benefits. The Benefits Fairs run from April 7 through April 23 and a schedule is provided for you in the back of this booklet.

The State of West Virginia continually recognizes the need to provide quality benefits to its employees. We want to make sure that you and your family have the protection you need. I urge you to look closely at the benefits offered through this program.

Sincerely,

Joe Manchin III

Employee Benefits Resource Directory

Delta Dental of West Virginia
(Dental) Plan #1058
Customer Service
Mon - Fri, 8 a.m. - 8 p.m. ET
1-800-932-0783
www.MidAtlanticDeltaDental.com

Vision Service Plan
(Vision)
Customer Service
Mon - Fri, 8 a.m. - 7 p.m. ET
1-800-877-7195
www.vsp.com

Standard Insurance Company
(STD) Policy #611506-B
(LTD) Policy #611506-A
STD/LTD Claims
Mon - Fri, 10 a.m. - 9 p.m. ET
1-800-368-2859
www.standard.com

Fringe Benefits Management Company (Flexible Spending Accounts)
FBMC Customer Service
Mon - Fri, 7 a.m. - 10 p.m. ET
1-800-342-8017

FBMC Toll-Free Claims Fax
1-866-440-7145

FBMC Automated Services
24 hours a day
1-800-865-FBMC (3262)
www.myFBMC.com

EZ REIMBURSE® MasterCard® Card
Lost or Stolen Card
24 hours a day
1-800-689-0821

Dispute Line
FBMC Customer Service
Mon - Fri, 7 a.m. - 10 p.m. ET
1-800-342-8017

Activation Line
24 hours a day
1-866-300-7624

Hyatt Legal Plans, Inc.
(Legal)
Client Service Center
Mon - Thurs, 8 a.m. - 7 p.m. ET
Fri, 8 a.m. - 6 p.m. ET
1-800-821-6400
www.legalplans.com

Trustmark Insurance Company*
(LifeEvents®)
Customer Service
Mon - Fri, 8 a.m. - 7 p.m. ET
1-800-918-8877
www.trustmarkinsurance.com

Important Dates to Remember
Your Open Enrollment dates are:
April 1, 2008, through April 30, 2008.

Your Period of Coverage dates are:
July 1, 2008, through June 30, 2009.

*Trustmark no longer offers new LifeEvents® policies. Employees who currently have LifeEvents® may continue coverage.

Table of Contents

5 Enrollment at a Glance

6 Getting Answers

7 Completing Your Enrollment Form

8 Eligibility Requirements

9 Flexible Spending Accounts (FSAs)

11 Medical Expense FSA

13 EZ REIMBURSE® MasterCard® Card

14 Dependent Care FSA

16 FSA Worksheets

17 Delta Dental – Dental Care Plans

19 Vision Service Plan

21 Long-term Disability Income Plans

23 Short-term Disability Income Plan

24 Group Legal Plan (Post-tax)

25 Changing Your Coverage

27 COBRA Q&A

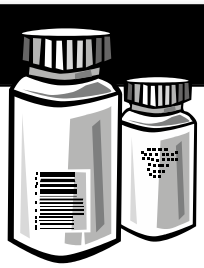
29 Beyond Your Benefits

31 Benefit Fair Schedule

What's New

- FBMC has introduced a new way to login to **www.myFBMC.com**. If you have not already, you will need to register following the first time user link provided.
- The Delta Dental Assistance Plan has been improved to offer better Diagnostic and Preventive services.

Save money on your next trip to the drugstore!



See FSA pages in this Reference Guide for details.

Enrollment at a Glance

Important Enrollment Information

- Open Enrollment is April 1, 2008, through April 30, 2008.
- Return your completed Enrollment Form to your Benefit Coordinator by April 30, 2008, to make changes to your current benefits.
- This is a changes-only enrollment. Therefore, all benefit selections will continue for the new plan year as currently enrolled. Complete an Enrollment Form if you would like to add, change or cancel coverage.
- Your 2009 Plan Year is July 1, 2008, through June 30, 2009.
- If you choose to receive the EZ REIMBURSE® Card by checking the appropriate box on your Enrollment Form, you will be assessed a $15, non-refundable annual fee. See Page 13 for more details.
- For more information, visit Fringe Benefits Management Company (FBMC) Web site at **www.myFBMC.com**, or call 1-800-342-8017, 7 a.m. - 10 p.m., Monday through Friday.

Making your benefits work for you — it's easy!

- Fringe Benefits Management Company (FBMC), your employee benefits administrator, along with your employer, offer you a wide selection of benefits to choose from during your Open Enrollment. FBMC specializes in tax-saving benefits administration, including Flexible Spending Accounts (FSAs), which may save you a significant amount of your annual income.
- FBMC provides you with convenient ways to track your benefit transactions, including online review, telephone tracking and statements.
- Before you sign up for an FSA, review the FSA guidelines and become familiar with how the program works. See how to save yourself and your family a significant amount of taxes. For more information, refer to the Flexible Spending Accounts section beginning on Page 9 of this Reference Guide.
- Remember to submit your supporting documentation, billing statements or invoices along with your EZ REIMBURSE® Card Transmittal Sheet when using your EZ REIMBURSE® Card.
- Submit your supporting documentation and completed reimbursement request form (for paper claims) to FBMC for reimbursement processing. Once the plan year ends, you have a 120-day run-out period to submit your supporting documentation.
- You may visit FBMC's Web site at **www.myFBMC.com** for more information. You may also contact FBMC Customer Service at 1-800-342-8017.

Benefit Fairs

Benefit Fairs will take place April 7, 2008, through April 23, 2008. Benefit Fairs allow you access to specific information on each of your benefits. You're invited to ask questions, share your concerns and gain more knowledge about the coverages you select.

Enrollment Counselors will be available at the Benefit Fairs to:

- provide you with detailed benefit information
- answer any benefit questions, and
- help you complete your Enrollment Form.

Bring your dependents' Social Security numbers and dates of birth with you to complete the dependent section of the Enrollment Form.

Remember, an Enrollment Counselor's incentive and objective is your satisfaction!

See the schedule of Benefit Fairs at the back of this Reference Guide for times and locations.

Enrollment Forms

- **Enrolling for the first time?** You must complete an Enrollment Form and make your benefit selections by checking the "Add Coverage" box.
- **Changing your benefits?** You must complete an Enrollment Form and change your selections by checking the "Change Coverage" box. Complete the line with the new coverage information.
- **Adding a new benefit?** You must complete an Enrollment Form and make your selections by checking the "Add Coverage" box. Complete the line with the new coverage information.
- **Keeping all of your current benefits?** You do not have to do anything. All benefits will continue as currently enrolled.
- **Canceling current benefits?** You must complete an Enrollment Form and check the "Cancel Coverage" box for the benefit you want to cancel; otherwise it will automatically continue for the 2009 Plan Year.

Enrollment Deadline: Sign and date your Enrollment Form. Remember to keep the bottom, goldenrod copy for your records. Submit the top three copies to your Benefit Coordinator **no later than April 30, 2008.**

Attn: Benefit Coordinators—All applications must be sent to Fringe Benefits Management Company (FBMC) postmarked by May 7, 2008.

Getting Answers

Getting answers to many of your benefit questions is now easier than ever. FBMC Customer Service offers you a variety of resources to make inquiries on your benefits and Flexible Spending Accounts (FSAs), including information from the FBMC Web site, Interactive Voice Response system or Customer Service.

FBMC Web Site

Type "**www.myFBMC.com**" into your Internet browser to access FBMC's home page. Use the navigational tabs along the top of the Web page to get answers to many of your benefits questions.

If you previously registered an e-mail address and password on FBMC's Web site, you may continue using this information. If you haven't registered, or if you registered prior to January 19, 2008, log in to the site as a first time user. Follow the link on the login page and register through the FBMC Premier Login.

Benefits

You may check your benefit status, read benefit descriptions, check out our tax calculator and much more.

Claims

Not only can you check the status of your claim, but you may also download forms, get more information about mailing and faxing your claim to FBMC or see transactions that need documentation.

Accounts

View your account balance and contributions. You may also view monthly statements and review your transaction history.

EZ REIMBURSE® MasterCard® Card

You may download a card fact sheet or transmittal form, read detailed instructions on proper use and open our IIAS Certified Merchant List to maximize card convenience.

Profile

Change the e-mail address we have on file, complete your online registration or select a new PIN.

Resources

Peruse our extensive resource library, including benefit materials, surveys, Over-the-Counter drug listings and benefit tips.

Forms

Download applicable forms for claim submission and reimbursement.

FBMC Interactive Benefits

FBMC's 24-hour automated phone system, Interactive Voice Response (IVR), can be reached by calling 1-800-865-FBMC (3262). This system allows you to access your benefits any time. By following the voice prompts, you can find out a great deal of information about your benefits.

- Current Account Balance(s)
- Claim Status
- Mailing Address Verification
- Obtain FSA Reimbursement Request Claim Forms
- Change Your PIN

Personal Identification Number (PIN)

To access Interactive Voice Response (IVR) system, all you need is your Social Security number (SSN). The last four digits of your SSN will be your first PIN. After your initial login, you will be asked to register and select your own confidential PIN to access both systems in the future. Your new PIN cannot be the last four digits of your SSN, cannot be longer than eight digits and must be greater than zero.

Record PIN here.

Remember, this will be your PIN for IVR access.
If you forget your PIN, click the "Need Help?" link for help or you may call Customer Service at **1-800-342-8017**.

Record Password here.

This will be your Web site login password. If you forget your password follow click the "Forgot Your Password?" link on **www.myFBMC.com** to retrieve it or contact FBMC Customer Service at **1-800-342-8017**.

Note: Please be sure to keep this Reference Guide in a safe, convenient place, and refer to it for benefit information.

Completing Your Enrollment Form

Who needs to complete an Enrollment Form?

- New participants who want to enroll for the first time
- Employees who want to add, change or cancel coverage for the new plan year
- Employees who need to update dependent information.

If you are not making any changes to your benefits, you do not need to complete an Enrollment Form. However, if you do not currently have an EZ REIMBURSE® MasterCard® Card and wish to participate in the program, you must complete an Enrollment Form. Likewise, if you currently have an EZ REIMBURSE® Card and do not wish to participate in the program any longer, you must also complete an Enrollment Form.

Web Enrollment

Employees may choose to enroll on our Web site at **www.myFBMC.com**. You must be registered to access the Web enrollment. If you have not already, you will need to register following the first time user link provided. Once registered, you may access the Web enrollment instructions at the "Resources" tab.

If you:

- are a new hire after 3/1/08
- currently do not participate and work for a non-state agency or a County Board of Education

You may not enroll on our Web site but must use an enrollment form.

Note: This is a "changes only" enrollment. If you have no changes you do not have to do anything and your benefits will remain the same.

Enrollment Form Section 1

Complete all of your personal information.

Enrollment Form Section 3

For each benefit you are adding, changing or canceling, you must check the appropriate box next to the corresponding benefit. For the benefit selections you are not altering, check the "Keep Coverage" box. If you complete an Enrollment Form but do not indicate your desire to cancel or change an existing benefit, that benefit will continue regardless of other benefits which may or may not be indicated on the Enrollment Form.

Remember to complete all requested information for your benefits.

Dental Care: Select a Delta Dental plan.

- All employees are eligible to enroll in any Delta Dental plan.
- Check the type of coverage you are choosing and enter the cost per-pay-period amount in the box on the right.
- If you are selecting 'Employee & Children,' 'Employee & Spouse' or 'Employee & Family' coverage, you must complete the dependent information in Section 4.

Vision Care: You may choose either the Full Service plan or the Exam Plus plan, but not both. Check the type of coverage you are choosing, and enter the cost per-pay-period in the box on the right. If you select 'Employee & Family' coverage, you must complete the dependent information in Section 4.

Long-term Disability Income Plans: This benefit is for employees only. You must select a plan with a coverage level of either 60 percent or 40 percent of your salary. See Page 22 for help in calculating your per-paycheck deduction amount, then enter this cost per pay period on your enrollment form.

Short-term Disability Income Plan: This benefit is for employees only. See Page 23 for help in calculating your per-paycheck deduction amount, then enter this cost per-pay-period on your Enrollment Form.

Medical Expense Flexible Spending Account: Enter your per-pay-period contribution in the space to the right. Refer to the FSA worksheets on Page 16 for help in computing your amount.

Dependent Care Flexible Spending Account: Enter your per-pay-period contribution in the space to the right. Refer to the FSA worksheets on Page 16 for help in computing your amount.

Add your total per-pay-period administrative fees from the bottom of Page 16 ($1.96/month for one or both FSAs) to your per-pay-period benefit costs. This is your total tax-free salary deduction amount per pay period.

Hyatt Legal Plan: Enter the cost per pay period. Remember, this premium is paid on a post-tax basis.

Enrollment Form Section 4

If you selected dependent coverage (child, spouse, family) for dental, vision or legal benefits, you must complete this section. This includes the dependents' names, relationship to you, birth dates and Social Security numbers.

Sign and date the form at the bottom. Please keep the goldenrod copy for your records. Return the top three copies of your completed form to your Benefit Coordinator no later than April 30, 2008.

Your Benefit Coordinator will process your application and send it to FBMC postmarked by May 7, 2008.

Eligibility Requirements

Who is Eligible?
All active employees of State agencies, colleges and universities and participating County Boards of Education are eligible to participate in this program. This program is also offered to non-State agencies. Please check with your benefits department to see if you are eligible.

Upon certain qualifying events, spouses, children and employees may be eligible for group health plan coverage under COBRA law. Please contact FBMC at 1-800-342-8017 for more information.

Period of Coverage
Your period of coverage begins on July 1, 2008, and continues until June 30, 2009, unless you:
- terminate employment
- go on an unpaid leave of absence or
- change your benefit elections in limited circumstances as further discussed under "Changing Your Coverage."

COBRA Coverage
If you terminate your employment, retire or go on unapproved leave, you can continue certain benefits by calling FBMC Customer Service at 1-800-342-8017. According to federal and state law, you can continue your own and your dependents' coverage if you terminate employment or have certain other Qualifying Events under COBRA. You will be notified of your rights and any continuable benefits you may have after you have notified FBMC that you have a Qualifying Event. Call FBMC at 1-800-342-8017 for details.

If you participated in a Medical Expense FSA and a triggering event occurred during the plan year making you eligible to continue your Medical Expense FSA under COBRA until that plan year ended, your Medical Expense FSA coverage will be cancelled at the end of the plan year in which the triggering event occurred, unless otherwise required by law.

Retiree Coverage
During the 90 days prior to your anticipated retirement date, contact FBMC for your enrollment packet to continue your dental and/or vision plan.

HIPAA-Special Enrollment Rights Pertaining to Group Health Plans
If you are declining enrollment for yourself or your dependent(s) (including your spouse) because of other health insurance coverage, you may, in the future, be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after the other coverage ends.

Employees on Leave
Approved Medical Leave: If you go on medical leave because of your own disability (which includes pregnancy and disabilities resulting from pregnancy complications), your premium deductions will continue through the Mountaineer Flexible Benefits Plan as long as you receive a salary. The Family and Medical Leave Act may affect your rights concerning the continuation of your health benefits while on unpaid leave. Call FBMC at 1-800-342-8017 for further information.

Approved Unpaid Leave: You can continue to receive coverage for certain benefits for the duration of your leave if you pay your premium to FBMC on an after-tax basis.

If you have not maintained a current premium status while on leave, you will be required to re-satisfy eligibility requirements when you return to active status, except as otherwise provided by law. Call Customer Service at 1-800-342-8017 for further information on billing if you go on approved, unpaid leave.

Appeal Process
If you have a request (an FSA claim for reimbursement, Change-In-Status (CIS) request or other similar request) denied, in full or in part, you have the right to appeal the decision by sending a written request to FBMC for review within 30 days of the denial.

Your appeal must state: (i) why you think your request should not have been denied, (ii) the name of your employer, (iii) the date of the services for which your request was denied, (iv) a copy of the denied request, (v) the denial letter you received, and (vi) any additional documents, information or comments you think may have a bearing on your appeal. Call FBMC Customer Service at 1-800-342-8017 to discuss your appeal.

Upon FBMC's receipt of your appeal and supporting documentation, it will be reviewed. You will normally be notified of the results of this review within 30 business days from receipt of your written appeal. In unusual cases, such as when review of your appeal requires additional documentation, the review may take longer than 30 business days. If your appeal is approved, additional processing time is required to modify your benefit elections.

PLEASE NOTE: Appeals are approved only if the extenuating circumstances and supporting documentation are within IRS regulations governing the plan.

Flexible Spending Accounts

What is a Flexible Spending Account?

Fringe Benefits Management Company (FBMC) provides you with IRS tax-favored Flexible Spending Accounts (FSAs) to stretch your medical expense and dependent care dollars.

Flexible Spending Accounts feature:

- IRS-approved reimbursement of eligible expenses tax-free
- per-pay-period deposits from your pre-tax salary
- savings on income and Social Security taxes and
- security of paying anticipated expenses with your FSA.

Is an FSA right for me?

If you spend $150 or more on recurring eligible expenses during your plan year, you may save money by paying for them with an FSA. A portion of your salary is deposited into your FSA each pay period.

- You decide the amount you want deposited.
- You are reimbursed for eligible expenses before income and Social Security taxes are deducted.
- You save income and Social Security taxes each time you receive wages.
- Determine your potential savings with a Tax Savings Analysis by visiting the "Tax Calculators" link at **www.myFBMC.com**.

What types of FSAs are available?

Your employer offers you a Medical Expense FSA as well as a Dependent Care FSA. If you incur both types of expenses during a plan year, you can establish both types of FSAs.

Medical Expense FSAs

Medical expenses not covered by your insurance plan may be eligible for reimbursement using your Medical Expense FSA, including:

- birth control pills
- eyeglasses
- orthodontia and
- Over-the-Counter items.

Dependent Care FSAs

Dependent care expenses, whether for a child or an elder, include any expense that allows you to work, such as:

- daycare services
- in-home care
- nursery and preschool and
- summer day camps.

Refer to the Medical Expense FSA and Dependent Care FSA sections of this Reference Guide for specifics on each type of FSA.

Receiving Reimbursement

Your reimbursement will be processed within five business days from the time FBMC receives your properly completed and signed FSA Reimbursement Request Form. To avoid delays, follow the instructions for submitting your requests located in the FSA materials you will receive following enrollment.

Direct Deposit

Enroll in Direct Deposit to expedite the time of your reimbursement.

- FSA reimbursement funds are automatically deposited into your checking or savings account within 48 hours of your claim approval.
- There is no fee for this service.
- You don't have to wait for postal service delivery of your reimbursement (however, you will receive notification that the claim has been processed).

To apply, complete the Direct Deposit Enrollment Form available from your **Enrollment Counselor**, visit **www.myFBMC.com** or call FBMC Customer Service at 1-800-342-8017. Please note that processing your Direct Deposit enrollment may take between four to six weeks.

Where can I get information about FSAs?

If you have specific questions about FSAs, contact FBMC Customer Service.

- Visit **www.myFBMC.com**.
- Call **1-800-342-8017** (Monday - Friday, 7 a.m. - 10 p.m. ET).

Please note that due to FBMC's Privacy Policy, we will not discuss your account information with others without your verbal or written authorization.

FSA Savings Example*

(With FSA)		*(Without FSA)*
$31,000	Annual Gross Income	$31,000
- 5,000	FSA Deposit for Recurring Expenses	- 0
$26,000	Taxable Gross Income	$31,000
- 5,889	Federal, Social Security Taxes	-7,021
$20,111	Annual Net Income	$23,979
- 0	Cost of Recurring Expenses	-5,000
$20,111	Spendable Income	$18,979

By using an FSA to pay for anticipated recurring expenses, you convert the money you save in taxes to additional spendable income. That's a potential annual savings of

$1,132!

* Based upon a 22.65% tax rate (15% federal and 7.65% Social Security) calculated on a calendar year.

Flexible Spending Accounts

Continued

FSA Guidelines:

1. The IRS does not allow you to pay your medical or other insurance premiums through either type of FSA.
2. You cannot transfer money between FSAs or pay a dependent care expense from your Medical Expense FSA or vice versa.
3. You have a 120-day run-out period (until October 31, 2009) at the end of the plan year for reimbursement of eligible FSA expenses incurred during your period of coverage and any applicable grace period within the 2009 Plan Year.
4. You may not receive insurance benefits or any other compensation for expenses that are reimbursed through your FSAs.
5. You cannot deduct reimbursed expenses for income tax purposes.
6. You may not be reimbursed for a service that you have not yet received.
7. Be conservative when estimating your medical and/or dependent care expenses for the 2009 Plan Year. IRS regulations state that any unused funds that remain in your FSA after a plan year and any applicable grace period ends, and all reimbursable requests have been submitted and processed, cannot be returned to you or carried forward to the next plan year.
8. When enrolling in either or both FSAs, written notice of agreement with the following will be required.
   - I will only use my FSA to pay for IRS-qualified expenses eligible under my employer's plan, and only for me and my IRS-eligible dependents
   - I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s) before seeking reimbursement from my FSA
   - I will not seek reimbursement through any additional source and
   - I will collect and maintain sufficient documentation to validate the foregoing.

What documentation of expenses do I need to keep?

The IRS requires FSA customers to maintain complete documentation, including keeping copies of statements, invoices or bills for reimbursed expenses, for a minimum of one year.

How do I get the forms I need?

To obtain forms you will need after enrolling in either a Medical Expense or Dependent Care FSA, such as an FSA Reimbursement Request Form, Letter of Medical Need or Direct Deposit Form, you can visit FBMC's Web site, **www.myFBMC.com**, or call FBMC Customer Service at 1-800-342-8017. For more information, refer to the Getting Answers section of this Reference Guide.

Will contributions affect my income taxes?

Salary reductions made under a cafeteria plan, including contributions to one or both FSAs, will lower your taxable income and taxes. These reductions are one of the money-saving aspects of starting an FSA. Depending on the state, additional state income tax savings or credits may also be available. Your salary reductions will reduce earned income for purposes of the federal Earned Income Tax Credit (EITC).

To help you choose between the available taxable and tax-free benefits, or a combination of both, consult your tax adviser and/or the IRS for additional information.

FSA Grace Period

A recent IRS Revenue Notice permits a "**grace period**" of two months and 15 days following the end of your 2009 Plan Year (June 30, 2009) for an FSA. This grace period ends on September 15, 2009. **During the grace period, you may incur expenses and submit claims for these expenses.** Funds will be automatically deducted from any remaining dollars in your 2008 FSA.

You should not confuse the grace period with the plan's "**run-out period**." The run-out period extends until October 31, 2009. This is a period for filing claims incurred anytime during the 2009 Plan Year, as well as claims incurred during the grace period mentioned above.

Claims will be processed in the order in which they are received by FBMC and your accounts will be debited accordingly. This is true for both paper claims and EZ REIMBURSE® Card transactions. If you have funds remaining in an account for the prior plan year, these funds will be used first until exhausted. Then, subsequent claims will be debited from your new plan year account balance.

Medical Expense FSA

Minimum Annual Deposit*: **$150**
Maximum Annual Deposit*: **$5,000**
* Plus administrative fee

What is a Medical Expense FSA?

A Medical Expense FSA is an IRS tax-favored account you can use to pay for your eligible medical expenses not covered by your insurance or any other plan. These funds are set aside from your salary before taxes are deducted, allowing you to pay your eligible expenses tax-free. A partial list of these eligible expenses can be found on this page.

Whose expenses are eligible?

Your Medical Expense FSA may be used to reimburse eligible expenses incurred by:

- yourself
- your spouse
- your qualifying child or
- your qualifying relative.

An individual is a **qualifying child** if they are not someone else's qualifying child and:

- are a U.S. citizen, national or a resident of the U.S., Mexico or Canada
- have a specified family-type relationship to you
- live in your household for more than half of the taxable year
- are 18 years old or younger (23 years, if a full-time student) at the end of the taxable year and
- have not provided more than one-half of their own support during the taxable year.

An individual is a **qualifying relative** if they are a U.S. citizen, national or a resident of the U.S., Mexico or Canada and:

- have a specified family-type relationship to you, are not someone else's qualifying child and receive more than one-half of their support from you during the taxable year **or**
- if no specified family-type relationship to you exists, are a member of and live in your household (without violating local law) for the entire taxable year and receive more than one-half of their support from you during the taxable year.

Note: There is no age requirement for a qualifying child if they are physically and/or mentally incapable of self-care. An eligible child of divorced parents is treated as a dependent of both, so either or both parents can establish a Medical Expense FSA.

Can travel expenses for medical care be reimbursed?

Travel expenses primarily for, and essential to, receiving medical care, including health care provider and pharmacy visits, may be reimbursable through your Medical Expense FSA. With proper substantiation, eligible expenses can include:

- actual round-trip mileage
- parking fees
- tolls and
- transportation to another city.

Are prescriptions eligible for reimbursement?

Yes, most filled prescriptions are eligible for Medical Expense FSA reimbursement, as long as you properly substantiate the expense. Proper submission of the reimbursement request is needed to ensure that the drug is eligible for reimbursement. The IRS requires the complete name of all medicines and drugs be obtained and documented on pharmacy invoices (including prescription number, date(s) of service and total dollar amount). This information must be included when submitting your request to FBMC for reimbursement.

Over-the-Counter Expenses

Your Over-the-Counter (OTC) items, medicines and drugs may be reimbursable through your Medical Expense FSA. Save valuable tax dollars on certain categories of OTC items, medicines and drugs, such as: allergy treatments, antacids, cold remedies, first-aid supplies and pain relievers. For a more comprehensive list of eligible OTC items, please visit **www.myFBMC.com**.

You may be reimbursed for OTCs through your Medical Expense FSA if:

- the item, medicine or drug was used for a specific medical condition for you, your spouse and/or your dependent(s)
- the submitted receipt clearly states the purchase date and name of the item, medicine or drug
- the reimbursement request is for an expense allowed by your employer's Medical Expense FSA plan and IRS regulations and
- you submit your reimbursement request in a timely and complete manner already described in your benefits enrollment information.

Note: OTC items, medicines and drugs, including bulk purchases, must be used in the same plan year in which you claim reimbursement for their cost. The list of eligible OTC categories will be updated on a quarterly basis by FBMC. It is your responsibility to remain informed of updates to this listing, which can be found at **www.myFBMC.com**. As soon as an OTC item, medicine or drug becomes eligible under any of the categories, it will be reimbursable retroactively to the start of the then-current plan year.

Newly eligible OTC items, medicines and drugs are not considered a valid change in status event that would allow you to change your annual Medical Expense FSA election or salary reduction amount. Be sure to maintain sufficient documentation to submit receipts for reimbursement. You may resubmit a copy of your receipt from your records if a rejected OTC expense becomes eligible for reimbursement later in the same plan year.

Is orthodontic treatment reimbursable?

Orthodontic treatment designed to treat a specific medical condition is reimbursable through your Medical Expense FSA if the proper documentation is provided:

- a written statement, bill or invoice from the treating dentist/orthodontist showing the type and date the service was incurred, the name of the eligible individual receiving the service, the cost for the service and
- a copy of the patient's contract with the dentist/orthodontist for the orthodontia treatment (only required if a participant requests reimbursement for the total program cost spread over a period of time).

Medical Expense FSA

Continued

Reimbursement of the full or initial payment amount may only occur during the plan year in which the braces are first installed. For reimbursement options available under your employer's plan, including care that extends beyond one or more plan years, refer to the information provided following your enrollment, or call FBMC Customer Service at 1-800-342-8017.

When are my funds available?

Once you sign up for a Medical Expense FSA and decide how much to contribute, the maximum annual amount of reimbursement for eligible health care expenses will be available throughout your period of coverage.

Since you don't have to wait for the cash to accumulate in your account, you can use it to pay for your eligible health care expenses at the start of your deductions.

*Partial List of Medically Necessary Eligible Expenses**

Acupuncture
Ambulance service
Birth control pills and devices
Chiropractic care
Contact lenses (corrective)
Dental fees
Diagnostic tests/health screening
Doctor fees
Drug addiction/alcoholism treatment
Drugs
Experimental medical treatment
Eyeglasses
Guide dogs
Hearing aids and exams
In vitro fertilization
Injections and vaccinations
Nursing services
Optometrist fees
Orthodontic treatment
Over-the-Counter items
Prescription drugs to alleviate nicotine withdrawal symptoms
Smoking cessation programs/treatments
Surgery
Transportation for medical care
Weight-loss programs/meetings
Wheelchairs
X-rays

Note: Budget conservatively. No reimbursement or refund of Medical Expense FSA funds is available for services that do not occur within your plan year and grace period.

* IRS-qualified expenses are subject to federal regulatory change at any time during a tax year. Certain other substantiation requirements and restrictions may apply, and will be supplied to you following enrollment.

Visit www.myFBMC.com for a list of frequently asked questions. You must keep your documentation for a minimum of one year and submit to FBMC upon request.

Should I claim my expenses on IRS Form 1040?

With a Medical Expense FSA, the money you set aside for health care expenses is deducted from your salary before taxes. It is always tax-free, regardless of the amount. By enrolling in a Medical Expense FSA, you guarantee your savings.

Itemizing your health care expenses on your IRS Form 1040 may give you a different tax advantage, depending on their percentage of your adjusted gross income. You should consult a tax professional to determine which avenue is right for you.

Are some expenses ineligible?

Expenses not eligible for reimbursement through your Medical Expense FSA include:

- insurance premiums
- vision warranties and service contracts and
- cosmetic surgery not deemed medically necessary to alleviate, mitigate or prevent a medical condition.

When do I request reimbursement?

You may use your Medical Expense FSA to reimburse eligible expenses after you have sought (and exhausted) all means of reimbursement provided by your employer and any other appropriate resource. Also keep in mind that some eligible expenses are reimbursable on the date available, not the date ordered.

How do I request reimbursement?

Requesting reimbursement from your Medical Expense FSA is easy. Simply mail or fax a correctly completed FSA Reimbursement Request Form along with the following:

- an invoice or bill from your health care provider listing the date you received the service, the cost of the service, the specific type of service and the person for whom the service was provided or
- an Explanation of Benefits (EOB)* from your health insurance provider that shows the specific type of service you received, the date and cost of the service and any uninsured portion of the cost and
- a written statement from your health care provider indicating the service was medically necessary if those services could be deemed cosmetic in nature, accompanied by the invoice or bill for the service.

Please note that cancelled checks or credit card receipts (or copies) listing the cost of eligible expenses are **not** valid documentation for Medical Expense FSA reimbursement.

Mail to: Contract Administrator
Fringe Benefits Management Company
P.O. Box 1800
Tallahassee, FL 32302-1800

Fax Toll-Free: 1-866-440-7145

* EOBs are not required if your coverage is through a HMO.

EZ REIMBURSE® MasterCard® Card

The EZ REIMBURSE® MasterCard® Card is issued by MetaBank.

What is the EZ REIMBURSE® MasterCard® Card?

The EZ REIMBURSE® Card is a payment card. It is a convenient Medical Expense FSA reimbursement option that allows FBMC to electronically reimburse eligible expenses under your employer's plan and IRS guidelines. Your annual Medical Expense FSA contribution is available to you at the beginning of your plan year. When you use your EZ REIMBURSE® Card to pay for eligible expenses, funds are electronically deducted from your Medical Expense FSA.

What are the EZ REIMBURSE® Card advantages?

You can use your EZ REIMBURSE® Card for your eligible Over-the-Counter (OTC) expenses at drugstores. Other advantages include:

- instant **reimbursements** for health care expenses, including prescriptions, co-payments and mail-order prescription services
- instant **approval of some** medical, prescription, vision and dental expenses (others require documentation)
- no out-of-pocket expense and
- easy access to your Medical Spending Account funds.

Note: You **cannot** use your EZ REIMBURSE® Card for cosmetic dental expenses or eye glass warranties.

How do I get an EZ REIMBURSE® Card?

You must elect to receive an EZ REIMBURSE® Card on your Enrollment Form when you start a Medical Expense FSA. Two cards will be sent to you in the mail; one for you, and one for your spouse or eligible dependent. You should keep your cards to use each plan year until their expiration date.

What if I already have an EZ REIMBURSE® Card?

You will not be issued a new card; continue using the same card(s) you have.

What does it cost to use the EZ REIMBURSE® Card?

There is a $15 non-refundable, annual fee for using the card. This amount is automatically deducted from your Medical Expense FSA. When you budget for your FSA deductions, you may want to consider the fee in your calculations.

How do I use my EZ REIMBURSE® Card?

For eligible expenses, simply swipe your EZ REIMBURSE® Card like you would with any other payment card. The amount of your eligible expenses will be automatically deducted from your Medical FSA. You will receive instant reimbursement for known health care expenses such as prescriptions and co-payments. Enhancements have been made to the EZ REIMBURSE® Card that allows participants to use the card at more places without having to submit documentation. Merchants are now updating their Inventory Information Approval Systems (IIAS) to allow for quick and easy card purchases. For more information on IIAS and to see the **IIAS Certified Merchant List**, with participating drug stores and pharmacies near you, please visit **www.myFBMC.com**.

When do I send in documentation for an EZ REIMBURSE® Card expense?

You must send in documentation for certain EZ REIMBURSE® Card transactions, such as those that are **not** a known office visit or prescription co-payment (as outlined in your health plan's Schedule of Benefits). When requested, you must send in documentation for these transactions. Documentation for an EZ REIMBURSE® Card expense is a statement or bill showing:

- name of the patient
- name of the service provider
- date of service
- type of service (including prescription name) and
- total amount of service.

Note: This documentation must be sent with an ***EZ REIMBURSE® Card Transmittal Sheet*** and cannot be processed without it. Like all other FSA documentation, you must keep your EZ REIMBURSE® Card expense documentation for a minimum of one year, and submit it to FBMC when requested.

As an FSA participant, you should go to **www.myFBMC.com** to see your account information and check for any outstanding Card transactions. If an outstanding transaction appears in **red** on the Web site or in **blue** in the Outstanding EZ Reimburse Transactions requiring Documentation section of your monthly statement, you must submit the proper expense documentation to FBMC prior to the end of your run out period.

If you fail to send in the requested documentation for an EZ REIMBURSE® Card expense, you will be subject to:

- withholding of payment for an eligible paper claim to offset any outstanding EZ REIMBURSE® Card transaction
- suspension of your EZ REIMBURSE® Card privileges
- the reporting of any outstanding EZ REIMBURSE® Card transaction amounts as income on your W-2 at the end of the tax year.
- Payback through payroll

What agreement am I making when I use the EZ REIMBURSE® Card?

By using the EZ REIMBURSE® Card, you are agreeing to the "FSA Guidelines" portion of this reference guide (on page 10). For more information about the EZ Reimburse® Card see the Cardholder Agreement that accompanies it.

What happens if I have money left in my account at the end of the plan year?

These funds will be used first until exhausted — through September 15, 2008, which is the grace period allowed by the IRS. Then, subsequent claims will be debited from your new plan year account balance. For more information on the grace period, see page 10.

Dependent Care FSA

Minimum Annual Deposit*: $150
Maximum Annual Deposit*: The maximum contribution depends on your tax filing status as the list below indicates.
* Plus administrative fee

What is a Dependent Care FSA?

A Dependent Care FSA is an IRS tax-favored account you can use to pay for your eligible dependent care expenses to ensure your dependents (child or elder) are taken care of while you and your spouse (if married) are working. These funds are set aside from your salary before taxes are deducted, allowing you to pay your eligible expenses tax-free. A partial list of these eligible expenses can be found on this page.

Whose expenses are eligible?

You may use your Dependent Care FSA to receive reimbursement for eligible dependent care expenses for qualifying individuals.

A qualifying individual includes a **qualifying child** if they:
- are a U.S. citizen, national or a resident of the U.S., Mexico or Canada
- have a specified family-type relationship to you
- live in your household for more than half of the taxable year
- are 12 years old or younger and
- have not provided more than one-half of their own support during the taxable year.

A qualifying individual includes your **spouse** if they:
- are physically and/or mentally incapable of self-care
- live in your household for more than half of the taxable year and
- spend at least eight hours per day in your home.

A qualifying individual includes your **qualifying relative** if they:
- are a U.S. citizen, national or a resident of the U.S., Mexico or Canada
- are physically and/or mentally incapable of self-care
- are not someone else's qualifying child
- live in your household for more than half of the taxable year
- spend at least eight hours per day in your home and
- receive more than one-half of their support from you during the taxable year.

Note: Only the custodial parent of divorced or legally-separated parents can be reimbursed using the Dependent Care FSA.

What is my maximum annual deposit?

- If you are married and filing separately, your maximum annual deposit is $2,500.
- If you are single and head of household, your maximum annual deposit is $5,000.
- If you are married and filing jointly, your maximum annual deposit is $5,000.
- If either you or your spouse earn less than $5,000 a year, your maximum annual deposit is equal to the lower of the two incomes.
- If your spouse is a full-time student or incapable of self-care, your maximum annual deposit is $3,000 a year for one dependent and $5,000 a year for two or more dependents.

When are my funds available?

Once you sign up for a Dependent Care FSA and decide how much to contribute, the funds available to you depend on the actual funds in your account. Unlike a Medical Expense FSA, the entire maximum annual amount is not available during the plan year, but rather after your payroll deductions are received.

Should I claim tax credits or exclusions?

Since money set aside in your Dependent Care FSA is always tax-free, you guarantee savings by paying for your eligible expenses through your IRS tax-favored account. Depending on the amount of income taxes you are required to pay, participation in a Dependent Care FSA may produce a greater tax benefit than claiming tax credits or exclusions alone.

Remember, you cannot use the dependent care tax credit if you are married and filing separately. Further, any dependent care expenses reimbursed through your Dependent Care FSA cannot be filed for the dependent care tax credit, and vice versa.

To help you choose between the available taxable and tax-free benefits, or a combination of both, consult your tax adviser and/or the IRS for additional information. You may also visit **www.myFBMC.com** to complete a Tax Savings Analysis.

Partial List of Eligible Expenses*
After school care
Baby-sitting fees
Daycare services
In-home care/au pair services
Nursery and preschool
Summer day camps

Note: Budget conservatively. No reimbursement or refund of Dependent Care FSA funds is available for services that do not occur within your plan year.

* IRS-qualified expenses are subject to federal regulatory change at any time during a tax year. Certain other substantiation requirements and restrictions may apply, and will be supplied to you following enrollment.

Continued

Are some expenses ineligible?

Expenses not eligible for reimbursement through your Dependent Care FSA include:

- books and supplies
- child support payments or child care if you are a non-custodial parent
- health care or educational tuition costs and
- services provided by your dependent, your spouse's dependent or your child who is under age 19.

Will I need to keep any additional documentation?

To claim the income exclusion for dependent care expenses on IRS Form 2441 (Child and Dependent Care Expenses), you must be able to identify your dependent care provider. If your dependent care is provided by an individual, you will need their Social Security number for identification, unless he or she is a resident or non-resident alien who does not have a Social Security number. If your dependent care is provided by an establishment, you will need its Taxpayer Identification number.

If you are unable to obtain a dependent care provider's information, you must provide a written statement that explains the circumstances and states that you made a serious and earnest effort to get the information. This statement must accompany your IRS Form 2441.

When do I request reimbursement?

You can request reimbursement from your Dependent Care FSA as often as you like. However, your approved expense will not be reimbursed until the last date of service for which you are requesting reimbursement has passed. Also, remember that for timely processing of your reimbursement, your payroll contributions must be current.

How do I request reimbursement?

Requesting reimbursement from your Dependent Care FSA is easy. Simply mail or fax a correctly completed FSA Reimbursement Request Form along with documentation showing the following:

- the name, age and grade of the dependent receiving the service
- the cost of the service
- the name and address of the provider and
- the beginning and ending dates of the service.

Be certain you obtain and submit the above information when requesting reimbursement from your Dependent Care FSA. This information is required with each request for reimbursement. Cancelled checks or credit card receipts (or copies) listing the cost of eligible expenses are **not** valid documentation for Dependent Care FSA reimbursement.

Mail to: Contract Administrator
Fringe Benefits Management Company
P.O. Box 1800
Tallahassee, FL 32302-1800

Fax Toll-Free: 1-866-440-7145

Note: If you elect to participate in the Dependent Care FSA, or if you file for the Dependent Care Tax Credit, you must attach IRS Form 2441, reflecting the information above, to your 1040 income tax return. Failure to do this may result in the IRS denying your pre-tax exclusion.

Be certain you obtain and submit all needed information when requesting reimbursement from your Dependent Care FSA. This information is required with each request for reimbursement.
A properly completed request will help speed along the process of your reimbursement, allowing you to receive your check or Direct Deposit promptly.

FSA Worksheets

To figure out how much to deposit in your FSA, refer to the following worksheets. Calculate the amount you expect to pay during the plan year for eligible, uninsured out-of-pocket medical and/or dependent care expenses. This calculated amount (including the administrative fees) cannot exceed established IRS and plan limits. (Refer to the individual FSA descriptions in this Reference Guide for limits.)

Be conservative in your estimates, since any money remaining in your accounts cannot be returned to you or carried forward to the next plan year.

MEDICAL EXPENSE FSA WORKSHEET

Estimate your eligible, uninsured out-of-pocket medical expenses for the plan year.

UNINSURED MEDICAL EXPENSES

Health insurance deductibles	$ _____
Coinsurance or co-payments	$ _____
Vision care	$ _____
Dental care	$ _____
Prescription drugs	$ _____
Travel costs for medical care	$ _____
Other eligible expenses	$ _____
EZ REIMBURSE® MasterCard® Card annual, non-refundable fee	$ _____
TOTAL (cannot exceed $5,000)	$ _____
DIVIDE by the number of paychecks you will receive during the plan year.*	÷ _____
This is your pay period contribution.**	$ _____

* If you are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year.

DEPENDENT CARE FSA WORKSHEET

Estimate your eligible dependent care expenses for the plan year. Remember that your calculated amount cannot exceed the calendar year limits established by the IRS.

CHILD CARE EXPENSES

Daycare services	$ _____
In-home care/au pair services	$ _____
Nursery and preschool	$ _____
After school care	$ _____
Summer day camps	$ _____

ELDER CARE SERVICES

Daycare center	$ _____
In-home care	$ _____
TOTAL Remember, your total contribution cannot exceed IRS limits for the plan year and calendar year (including administrative fee).	$ _____
DIVIDE by the number of paychecks you will receive during the plan year.*	÷ _____
This is your pay period contribution.**	$ _____

* If you are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year.

**DIRECT DEPOSIT - No one likes waiting for their money, why are you?
With Direct Deposit there no fees for the service and your FSA reimbursement checks are deposited into the checking or savings account of your choice within 48 hours of claim approval.**

Please remember to include your $15 annual fees in your Medical Expense FSA contribution if you plan to use your EZ REIMBURSE® Card as a form of payment.

**** You will be assessed a per-pay-period FSA Administrative Fee (whether you select one or both plans). The per-pay-period fees are as follows:**

10 pay	12 pay	18 pay	20 pay	21 pay	22 pay	24 pay	26 pay
$2.35	$1.96	$1.31	$1.18	$1.12	$1.07	$0.98	$0.90

Delta Dental - Dental Care Plans

Strong, healthy teeth create beautiful smiles. To give your smile the care and attention it deserves, Delta Dental offers you the Dental Assistance, Basic and Enhanced Indemnity dental care plans.

With Delta Dental, you have complete freedom of choice in selecting a dentist. You can choose a dentist from the Delta Dental Premier® or Delta Dental PPO networks, or a dentist who does not participate in either network. Your choice of dentist can determine your cost savings.

There are 556 Delta Dental Premier dental office locations and 328 Delta Dental PPO dental office locations in West Virginia.

Delta Dental PPO dentists will accept the Delta Dental PPO Maximum Plan Allowance (MPA)* or the dentist's fee – whichever is less (the PPO Allowed Amount) – as payment in full for covered services. Copayments and deductibles may also apply.

Delta Dental Premier dentists will accept the Delta Dental Premier MPA (a slightly higher MPA) or the dentist's total charge – whichever is less (Premier Allowed Amount) – as payment in full for covered services. Copayments and deductibles may also apply.

Non-participating dentists do not contract with Delta Dental to limit their costs. For services received from non-participating dentists, you are responsible for these dentists' total charges without limit by Delta Dental, including applicable copayments and deductibles. Delta Dental will reimburse you for its portion of the Premier Allowed Amount.

Your total out-of-pocket payment is least if you go to a PPO dentist, is more if you go to a Premier dentist, and likely will be highest if you go to a non-participating dentist. Please call Delta Dental to find a participating dentist in your area at **1-800-932-0783**, or visit **www.deltadentalins.com**.

Employees who visit a dentist under the Delta Dental PPO Network or the Delta Dental Premier Network, will receive the benefit of increased plan year maximums.

This year, you may enroll in any of the following three dental programs:

Dental Assistance Plan

The Dental Assistance plan is a discounted fee-for-service, managed-cost dental plan that allows employees the freedom to choose any dentist for treatment, but they receive the greatest benefits when they visit a Delta Dental participating dentist.

Basic Plan

The Basic plan is a low-cost plan designed to cover preventive and basic services only. Please look carefully at the plan descriptions in the chart before making your choice.

Enhanced Plan

The Enhanced plan is the most comprehensive coverage offered with this program and covers preventive, basic and major restorative, orthodontic and TMJ services.

Further Information

You may cover your spouse and any children, stepchildren or foster children, up to age 25.

See the chart on the following page for a partial list of covered services. For more information concerning your benefits or to request a claim form, call the Interactive Benefits Information Line at 1-800-865-FBMC (3262).

There are no I.D. cards distributed with these plans.
Submit claim forms to:
Delta Dental of West Virginia
One Delta Drive
Mechanicsburg, PA 17055-6999

Customer Service: 1-800-932-0783 TTY/TDD: 1-888-373-3582.

Your Tax-Free Rates

Dental Assistance	**10 pay**	**12 pay**	**18 pay**	**20 pay**	**21 pay**	**22 pay**	**24 pay**	**26 pay**
Employee Only	$12.55	$10.46	$6.97	$6.28	$5.98	$5.71	$5.23	$4.83
Employee & Children	$25.16	$20.97	$13.98	$12.58	$11.98	$11.44	$10.49	$9.68
Employee & Spouse	$28.07	$23.39	$15.59	$14.03	$13.37	$12.76	$11.70	$10.80
Employee & Family	$40.74	$33.95	$22.63	$20.37	$19.40	$18.52	$16.98	$15.67
Basic	**10 pay**	**12 pay**	**18 pay**	**20 pay**	**21 pay**	**22 pay**	**24 pay**	**26 pay**
Employee Only	$22.20	$18.50	$12.33	$11.10	$10.57	$10.09	$9.25	$8.54
Employee & Children	$44.47	$37.06	$24.71	$22.24	$21.18	$20.21	$18.53	$17.10
Employee & Spouse	$49.56	$41.30	$27.53	$24.78	$23.60	$22.53	$20.65	$19.06
Employee & Family	$71.88	$59.90	$39.93	$35.94	$34.23	$32.67	$29.95	$27.65
Enhanced	**10 pay**	**12 pay**	**18 pay**	**20 pay**	**21 pay**	**22 pay**	**24 pay**	**26 pay**
Employee Only	$35.82	$29.85	$19.90	$17.91	$17.06	$16.28	$14.93	$13.78
Employee & Children	$71.65	$59.71	$39.81	$35.83	$34.12	$32.57	$29.86	$27.56
Employee & Spouse	$83.20	$69.33	$46.22	$41.60	$39.62	$37.82	$34.67	$32.00
Employee & Family	$118.85	$99.04	$66.03	$59.42	$56.59	$54.02	$49.52	$45.71

* Maximum Plan Allowance is an amount, determined by Delta Dental, from claim charges submitted on a regional basis for a given service by dentists of similar training within the same geographical area. These charges are blended by Delta Dental with dentist fee information from a number of other sources, using various factors, subject to regulatory limitations and adjustment for extraordinary circumstances, such as extreme difficulty or unusual circumstances.

Plan #1058

Delta Dental – Dental Care Plans

Continued

Partial List of Covered Services	DENTAL ASSISTANCE PLAN	BASIC PLAN	ENHANCED PLAN
DEDUCTIBLE (per person per plan year)	You pay $25 (applies to all services)†	You pay $25 (applies to all service)†	You pay $50 (diagnostic, preventive and ortho are exempt)
Maximum total family deductible	$75	$75	$150
Plan year max (per person)			
Delta Dental network dentist	$750	$750	$1,250
Non-participating dentist	$500	$500	$1,000
OTHER MAXIMUMS			
Ortho Lifetime Max.	N/A	N/A	$1,000
TMJ Disorder	N/A	N/A	$500
BENEFIT	**Plan pays**	**Plan pays**	**Plan pays**
Diagnostic/Preventive Services	**100%***	**80%***	**100%***
Visits/Exams (twice in a 12-month period)			
Routine cleaning (twice in a 12-month period)			
Fluoride treatments (to age 19, twice in a 12-month period)			
Bitewing X-rays (twice in a 12-month period)			
Space maintainers (to age 14)			
Sealants (to age 14, once in any 36-month period on unfilled permanent first and second molars)			
Basic Restorative	**25%***	**80%***	**80%***
Amalgam ("silver") and composite ("white" non-molar) fillings			
Oral Surgery	**25%***	**80%***	**80%***
Extractions			
Oral surgery procedures			
General Anesthesia w/ oral surgery procedures with one or more simple extractions and/or with surgical extractions for patients under age 19; and with three or more simple extractions and/or surgical extractions for patients age 19 and over.			
Endodontics	**25%***	**80%***	**80%***
Pulpal therapy			
Root canal therapy			
Periodontics	**25%***	**80%***	**80%***
Treatment for gums and supporting structures			
Major Restorative**	**NOT COVERED**	**NOT COVERED**	**50%***
Inlays, onlays, crowns			
Prosthodontic**	**NOT COVERED**	**NOT COVERED**	**50%***
Bridges			
Full and partial dentures			
Denture adjustments/relining			
Orthodontia** (For eligible employees, spouses, and dependent children to age 19)	**NOT COVERED**	**NOT COVERED**	**50%***
TMJ	**NOT COVERED**	**NOT COVERED**	**50%***

† Deductible waived for diagnostic/preventive procedures at Delta Dental PPO Provider. Deductible applies to all services rendered by Delta Dental Premier and non-participating dentists.

* Percentage is based on Delta Dental's applicable Maximum Plan Allowance or the dentist's fee, whichever is less (the Allowed Amount). The Delta Dental payment under the program, plus the patient payment, equals the Allowed Amount, which is accepted by Delta Dental participating dentists as full payment. Participating dentists are paid directly by Delta Dental, and by agreement cannot bill you more than the applicable copayment, deductible or charges where maximums have been exceeded for covered services. By selecting a participating dentist, you always limit your out-of-pocket costs. For services performed by non-participating dentists, Delta Dental sends the benefit payment directly to you. You are responsible for paying the non-participating dentist's total fee, which may include amounts in addition to your share of Delta Dental's Allowed Amount. Out-of-pocket costs may also include applicable copayments, deductibles, charges where maximums have been exceeded, and services not covered by the Group Dental Service Contract.

** Major Restorative, Prostodontics, and Orthodontics require 6 month plan participation.

Vision Service Plan

Vision Service Plan (VSP) offers you the Full Service or Exam Plus vision coverage plans to help pay for your eyecare needs.

Full Service Plan

The Full Service Plan covers you and your family for all routine eye care including eye exams, eyeglass lenses and frames, or contact lenses. When it's time for an eye exam and/or eyeglasses, you can see any VSP doctor you want, or use a non-member doctor.

The deductible for materials is $20. A member may receive an examination and contact lenses or spectacle lenses once every plan year. Contact lenses are in lieu of lenses and frames. In other words, if a member chooses to use the contact lens benefit, this utilizes the lenses and frame benefit. The member would then be eligible for the frame benefit on July 1st.

Participants receive a 20 percent discount on additional pairs of prescription glasses or non-prescription glasses, including sunglasses from a VSP Member Doctor. You can also receive a 15 percent discount on the participating doctor's professional fees when you purchase prescription contact lenses. This benefit is available in conjunction with your VSP contact lens allowance, or you can use it to purchase contacts in addition to glasses.

These discounts may be used for 12 months following the date of the covered eye examination and are available from any participating VSP Member Doctor.

VSP's Laser Vision Care Program now provides discounts for LASIK and PRK surgeries from network laser surgery centers. Contact your VSP doctor for more information.

You may choose to cover your family by selecting the "Employee & Family" rates. You may cover your spouse and any children, stepchildren or foster children up to age 19 or to age 25, if they are unmarried, full-time students.

Exam Plus Vision Plan

Exam Plus is an alternative to the Full Service plan. Under this plan, you must obtain services through a VSP member doctor. Benefits include an eye exam once every plan year and discounts on materials and professional services through VSP member doctors. Your co-payment is $10 for your eye exam.

For glasses, a 20 percent discount will be applied to a VSP doctor's usual and customary fee for prescription glasses and spectacle lens options.

Full Service Plan (Plan Year runs July 1 through June 30)

	VSP MEMBER DOCTOR	NON-MEMBER DOCTOR
Co-payments†		
Exam	**$20**	**$20**
Prescription Glasses	**$20**	**$20**
	Plan Pays	**Plan Pays**
Vision Examination** (every plan year)	Covered in Full	$35
Lenses (every plan year)***		
Single Vision Lenses**	Covered in full	$25
Bifocal Lenses (including progressive lenses)**	Covered in full	$40
Trifocal Lenses (including progressive lenses)**	Covered in full	$55
Lenticular Lenses**	Covered in full	$80
Frames (every other plan year)*** (up to $150 allowance)	Covered in full*	$45
Contacts Lenses** (in place of lenses and frames)		
Medically Necessary	Covered in full***	Exam & $210
Elective	Exam & $150	Exam & $105

† Co-payments apply in-network (VSP Member Doctor) at the time of service. Co-payments apply out-of-network and will be deducted from the doctor's charge.

* Within Plan Limitations. If you select a frame that costs more than your plan allowance, there will be an additional charge you will pay out of pocket. When you visit the VSP member doctor, ask him/her which frames are covered in full. The allowance is very competitive and ensures a good choice with little or no out-of-pocket cost.

There will be an extra cost if you select materials or services that are elective or cosmetic in nature, such as tints and scratch coatings. (These charges are audited by VSP to ensure that you are not paying more than necessary.)

** Exam and contact lenses are also covered once every plan year, if necessary, provided you have not received spectacle lenses in the same plan year. You may receive eyeglass frames every other plan year. You may receive either spectacle lenses or contact lenses in the plan year, but not both.

When you choose elective contacts instead of glasses, your $150 allowance applies to the cost of your lenses and the fitting/evaluation exam. This exam is in addition to your vision exam to ensure proper fit of contacts.

***There is a single materials co-payment of $20 on lenses and frames or medically necessary contact lenses.

Your Tax-free Rates

Full Service plan	**10 pay**	**12 pay**	**18 pay**	**20 pay**	**21 pay**	**22 pay**	**24 pay**	**26 pay**
Employee Only	$12.11	$10.09	$6.73	$6.05	$5.77	$5.50	$5.05	$4.66
Employee & Family	$29.44	$24.53	$16.35	$14.72	$14.02	$13.38	$12.27	$11.32

Vision Service Plan

Continued

(Vision Plan Year Runs July 1 through June 30)

For contact lenses, a 15 percent discount will be applied on VSP member doctor's professional services associated with all prescription contact lenses.

These discounts may be used for 12 months following the date of the covered eye examination and are available from any participating VSP Member Doctor.

VSP's Laser Vision Care Program now provides discounts for LASIK and PRK surgeries from network laser surgery centers. Contact your VSP doctor for more information.

You may choose to cover your family by selecting the 'Employee & Family' rates. You may cover your spouse and any children, stepchildren or foster children up to age 25, if they are unmarried and depend on you for support.

For a current list of available VSP doctors, go to www.vsp.com.

How To Use These Plans

To obtain vision care benefits, call a VSP member doctor, identify yourself as a VSP patient and make an appointment. The doctor's office will verify the patient's eligibility and plan coverage and obtain authorization from VSP. **There are no I.D. cards distributed with these plans.**

The doctor will explain any additional charges. After you pay your co-payment, the doctor will take care of all the paperwork.

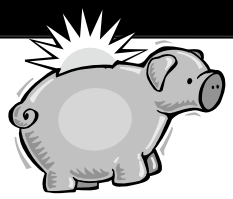
If you prefer, you can visit a nonmember doctor and pay the doctor's normal charges. Save your itemized receipt and mail it within six months of service date to:

Vision Service Plan
P.O. Box 997105
Sacramento, CA 95899-7105

For more information, contact VSP's Customer Service Line at 1-800-877-7195.

Your Tax-free Rates

Exam Plus plan	**10 pay**	**12 pay**	**18 pay**	**20 pay**	**21 pay**	**22 pay**	**24 pay**	**26 pay**
Employee Only	$2.03	$1.69	$1.13	$1.01	$0.97	$0.92	$0.85	$0.78
Employee & Family	$4.61	$3.84	$2.56	$2.30	$2.19	$2.09	$1.92	$1.77



Tired of the rising cost of health care? Get an FSA!

Learn more about how FSAs can alleviate your medical and dependent care expenses. See FSA pages in this Reference Guide for details.

Long-term Disability Income Plans

Employee Only, Pre-tax Benefit

Long-term Disability (LTD) insurance can help safeguard your family's lifestyle and provide some peace of mind in the event you become disabled and are unable to work.

Because the State of West Virginia's retirement plan may not provide you adequate protection in the event you become disabled, you should consider enrolling in one of the two Long-term Disability insurance plans offered by Standard Insurance Company.

When am I considered disabled?

During the benefit waiting period and the next 24 months you are considered disabled if, due to injury, physical disease, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of your own occupation, or you are unable to earn more than 80 percent of your pre-disability earnings while working in your own occupation.

Thereafter, you are considered disabled if, due to an injury, physical disease, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of any gainful occupation for which you are reasonably fitted by education, training and experience, or you are unable to earn more than 60 percent of your pre-disability earnings while working in your own or any other occupation.

What is the LTD benefit?

The monthly LTD benefit is based on your earnings from your public employer. The group insurance policy refers to these earnings as pre-disability earnings. The group policy has an actively-at-work requirement you must meet before your insurance will become effective.

You may apply for coverage under either Plan 1 or Plan 2. The monthly benefit under each plan is determined as follows:

Plan 1: 40 percent of the first $5,000 of your monthly pre-disability earnings, reduced by deductible income. The maximum monthly benefit is $2,000.

Plan 2: 60 percent of the first $4,167 of your monthly pre-disability earnings, reduced by deductible income. The maximum monthly benefit is $2,500.

Both Plans have a minimum monthly LTD benefit of $100.

What is deductible income?

Deductible Income is income you receive or are eligible to receive from other sources. It includes, but is not limited to: sick pay or other salary continuation, workers' compensation benefits, Social Security benefits, disability benefits from any other group insurance, 50 percent of earnings from work activity while you are disabled and disability or retirement benefits you receive or are eligible to receive because of your disability under any state disability benefit law or similar law or your retirement plan.

When do LTD benefits become payable?

If your LTD claim is approved by Standard Insurance Company, LTD benefits become payable at the end of the 180-day benefit waiting period. Refer to the Beyond Your Benefits section for information on taxes you may have to pay on insurance payments you receive.

How long can LTD benefits continue?

If you become continuously disabled before age 61, LTD benefits can continue during disability until age 65. If you become continuously disabled at age 62 or older, LTD benefits can continue during disability for a limited time. See the chart on Page 22.

What are the exclusions and limitations?

You are not covered for a disability caused or contributed to by: 1) a pre-existing condition (except as provided in your Certificate), 2) an intentionally self-inflicted injury or 3) war or any act of war. Benefits are not payable for more than 24 months for each period of disability caused or contributed to by a mental disorder, or for any period when you are not under the ongoing care of a physician.

What is the definition of a pre-existing condition?

If your disability results, directly or indirectly, from a pre-existing sickness or injury for which you, received medical treatment or services, took prescribed drugs or medicines, or consulted a Physician within three (3) months before the most recent effective date of your insurance, you will receive no monthly benefit for that condition. However, this limitation does not apply to a period of Disability that begins more than twelve (12) months after the most recent effective date of your insurance.

The Pre-existing Condition Limitation will apply to any added benefits or increases in benefits.

What are some of the features of this coverage?

- Coverage for disabilities occurring 24 hours a day both on or off the job.
- Insurance continues without premium payments while LTD benefits are payable.
- A survivors' benefit may be applicable if you die while LTD benefits are payable.

Policy Provider

Standard Insurance Company underwrites this plan. The A.M. Best Company, an organization that rates the financial strength and performance of insurance companies rates Standard Insurance Company "A" Excellent.

Long-term Disability Income Plans

Continued

How long are benefits payable?

Your benefits are payable according to the following schedule:

Age	Maximum Benefit Period
age 61 or younger	to age 65 (or 3 years, 6 months, if longer)
age 62	3 years, 6 months
age 63	3 years
age 64	2 years, 6 months
age 65	2 years
age 66	1 year, 9 months
age 67	1 year, 6 months
age 68	1 year, 3 months
age 69 +	1 year

Benefits are limited to 24 months for each period of continuous disability caused or contributed by a mental disorder. This limitation will not apply if you are confined in a hospital at the end of the 24 months.

This description is designed to answer some common questions about the Long-term Disability coverage. It is not intended to provide a detailed description of the plans. If you become insured, a more detailed description will be available in group insurance certificates provided to you. The controlling provisions are in the master group insurance policies. This description and the certificates do not modify the group policies or the insurance in any way.

For rules governing the taxes on the insurance payments you may receive, please read the Beyond Your Benefits section in the back of this Reference Guide.

PRE-TAX RATES FOR PLAN 1 (40% Coverage Level)

Age*	Monthly Premium Rate per $100 of Salary
to 29	$.175
30-34	.20
35-39	.255
40-44	.36
45-49	.52
50-54	.765
55-59	1.07
60-64	1.21
65-69	1.54
70 and over	1.98

* Age as of July 1, 2007. Disability Income Plan premiums are adjusted on an annual basis according to the employee's age and salary.

DISABILITY INCOME PROTECTION FORMULA

1. Enter your monthly salary (maximum $5,000) _____
2. Divide by 100 _____
3. Find your age on the chart above and enter the figure from the "Rate" column _____
4. Multiply the amount in Line 2 by the amount in Line 3 to get your monthly premium (based on 12 months). _____ Monthly Premium

If you are paid more than 12 times a year, you can calculate the amount to be deducted from your paycheck by completing the following chart.

5. Enter the monthly premium amount from Line 4 _____
6. Multiply by 12 _____
7. This is your annual premium _____
8. Divide by the number of regular paychecks you receive annually. _____ Per Paycheck Deduction

PRE-TAX RATES FOR PLAN 2 (60% Coverage Level)

Age*	Monthly Premium Rate per $100 of Salary
to 29	$.33
30-34	.405
35-39	.51
40-44	.71
45-49	1.05
50-54	1.56
55-59	2.04
60-64	2.18
65-69	2.44
70 and over	2.61

* Age as of July 1, 2007. Disability Income Plan premiums are adjusted on an annual basis according to the employee's age and salary.

DISABILITY INCOME PROTECTION FORMULA

1. Enter your monthly salary (maximum $4,167) _____
2. Divide by 100 _____
3. Find your age on the chart above and enter the figure from the "Rate" column _____
4. Multiply the amount in Line 2 by the amount in Line 3 to get your monthly premium (based on 12 months). _____ Monthly Premium

If you are paid more than 12 times a year, you can calculate the amount to be deducted from your paycheck by completing the following chart.

5. Enter the monthly premium amount from Line 4 _____
6. Multiply by 12 _____
7. This is your annual premium _____
8. Divide by the number of regular paychecks you receive annually. _____ Per Paycheck Deduction

Policy #611506-A

Short-term Disability Income Plan

Employee Only, Pre-tax Benefit

When am I considered disabled?

You are considered disabled if, due to sickness, injury or pregnancy, you are unable to perform with reasonable continuity the material duties of your own occupation or you are unable to earn more than 60 percent of your pre-disability earnings while working in your own occupation.

What is the STD benefit?

The weekly Short-term Disability (STD) benefit is based on your earnings from your public employer. The group insurance policy refers to these earnings as pre-disability earnings.

The weekly benefit is 60 percent of your pre-disability earnings, reduced by deductible income. The maximum weekly benefit is $500. The minimum weekly benefit is $15.

What is deductible income?

Deductible income includes 50 percent of earnings from work activity while you are disabled, and disability benefits you receive or are eligible to receive because of your disability under any state disability benefit law or similar law.

When do STD benefits become payable?

If your STD claim is approved by Standard Insurance Company, STD benefits become payable at the end of the 30-day benefit waiting period. During this 30-day period, no STD benefits are payable. The Group Policy has an actively-at-work requirement you must meet before your insurance will become effective.

How long can STD benefits continue?

STD benefits can continue during disability until no longer disabled, but no longer than the 180th day of disability.

What are the exclusions and limitations?

You are not covered for a disability caused or contributed to by: 1) a work-related injury, 2) an intentionally self-inflicted injury or 3) war or any act of war. Benefits are not payable for any period when you 1) receive or are eligible to receive sick leave, 2) are working for any employer other than the State of West Virginia or your public employer, 3) are eligible for any benefits under a workers' compensation act or similar law or 4) are not under the ongoing care of a physician.

This description is designed to answer some common questions about the Short-term Disability coverage. It is not intended to provide a detailed description of the plan. If you become insured, a more detailed description will be available in group insurance certificates provided to you. The controlling provisions are in the master group insurance policies. This description and the certificates do not modify the group policies or the insurance in any way.

For rules governing the taxes on the insurance payments you may receive, please read the Beyond Your Benefits section in the back of this Reference Guide.

Policy Provider

Standard Insurance Company underwrites this plan. The A.M. Best Company, an organization that rates the financial strength and performance of insurance companies rates Standard Insurance Company "A" Excellent.

YOUR PRE-TAX RATES

Example:

If your weekly salary is $350, your monthly premium would be calculated: $350 x $0.092 = $32.20 per month.

Worksheet

1. Your weekly salary (maximum $833.00) _____

X $0.092

2. This is your monthly premium _____

If you are paid more than 12 times a year, you can calculate the amount to be deducted from your paycheck by completing the following chart.

3. Enter the monthly premium amount from Line 2 _____
4. Multiply by 12 _____
5. This is your annual premium _____
6. Divide by the number of regular paychecks you receive annually. _____

Per Paycheck Deduction

Policy #611506-B

Group Legal Plan

A Payroll Deductible, Post-tax Benefit

Here's an affordable solution to help with your legal needs.

Finding an affordably priced lawyer to represent you when you buy or sell your home or even prepare your will can be a challenge. Did you ever wish you could pick up the phone and call a lawyer for some quick advice? For just pennies a day, the Legal Plan gives you your own "attorney on retainer." The Legal Plan also covers full representation for many important personal legal services.

How do I use the plan?

When you face a situation that you think may have legal implications, simply pick up the phone and call 1-800-821-6400 Monday-Thursday, 8 a.m. to 7 p.m., and Friday, 8 a.m. to 6 p.m. (Eastern Time). A knowledgeable client service representative will be available to assist you in locating a Plan Attorney near your home or workplace. Plan Attorneys are generally available to meet with you on weekdays, evenings and even Saturdays. Or, visit **www.legalplans.com**. If you're enrolled, click "Members Log In." If you have questions as you decide to enroll, click "Thinking about Enrolling?" and use WVA (all capital letters) as your password.

In or Out-of-Network?

Hyatt has more than 4,000 law firms in its nationwide network. When you use a Plan Attorney, covered legal services are provided at no additional attorney fees. Of course, you also have the flexibility to use a non-Plan Attorney and get reimbursed for covered services according to a set fee schedule. You will be responsible to pay the difference between the plan's payment and the Attorney's fees. It's completely your choice.

This is a brief summary of the Legal Plan. For definitions of covered services, visit Hyatt at **www.legalplans.com** or call 1-800-821-6400 and request a Fact Sheet.

What's covered?

- In-office Consultation & Telephone Advice with an attorney on virtually any personal legal matter
- Divorce & Separation
- Wills and Codicils* (see note)
- Identity Theft Defense
- Sale, Purchase of your Home
- Eviction Defense & Tenant Negotiations
- Juvenile Court Defense
- Traffic Ticket Defense (except DUI)
- Restoration of Driver's License
- Criminal Misdemeanor Defense
- Consumer Protection Matters
- Debt Collection Defense
- Uncontested Adoption
- Powers of Attorney
- Uncontested Guardianship
- Preparation of Deeds, Mortgages, Notes and Demand Letters

* Preparing for the future may be the most important thing you'll ever do for your family. Estate planning can be complex, and may require tax planning. You may need assistance from an accountant or financial planner. If you do require tax planning, whether it's done by an accountant, a financial planner or your Plan Attorney, you are responsible for paying the portion of the fees charged for tax planning. The Legal Plan does not cover the tax planning necessary to decide what documents you need.

Not covered?

If your legal matter is not listed as covered or excluded, your initial advice and consultation are free. If you need representation on a non-covered matter, your Plan Attorney will give you a written fee agreement in advance. This means that you will know, up front, what these services will cost.

What's excluded?

- Legal services for matters involving the State of West Virginia and any employment related matter
- Any business-related matters (including owned rental property)
- Appeals, class action suits and any matter where a spouse or dependent's interest might conflict with yours
- Payments made to a third party (someone other than the lawyer), such as court costs, witness fees or fines, filing fees, transcripts, recording fees or judgements

Group Legal Plan offered by Hyatt Legal Plans, Inc., Cleveland, OH. In certain states, provided through insurance coverage underwritten by Metropolitan Property and Casualty Company and Affiliates, Warwick, Rhode Island.

Your Rates for the Hyatt Legal Plan

	10 pay	**12 pay**	**18 pay**	**20 pay**	**21 pay**	**22 pay**	**24 pay**	**26 pay**
Employee & Family	$19.80	$16.50	$11.00	$9.90	$9.43	$9.00	$8.25	$7.62

Am I permitted to make mid-plan year election changes?

Under some circumstances, your employer's plan(s) and the IRS may permit you to make a mid-plan year election change to your FSA election, or vary a salary reduction amount, depending on the qualifying event and requested change.

How do I make a change?

You can change your Flexible Spending Account (FSA) election(s), or vary the salary reduction amounts you have selected during the plan year, only under limited circumstances as provided by your employer's plan(s) and established IRS guidelines. Partial lists of permitted and not permitted qualifying events under your employer's plan(s) appear on the following page. Election changes must be consistent with the event. FBMC will, in its sole discretion, review on a uniform and consistent basis, the facts and circumstances of each properly completed and timely submitted mid-plan year election change form.

To Make a Change: Within **30 days** of an event that is consistent with one of the events on the following page, you must complete and submit a Change in Status/Election Form to FBMC. Contact FBMC to obtain this form. Documentation supporting your election change request is required. Upon the approval and completion of processing your election change request, your existing FSA(s) elections will be stopped or modified (as appropriate). Generally, mid-plan year, pre-tax election changes can only be made prospectively, no earlier than the first payroll after your election change request has been received by FBMC, unless otherwise provided by law. If your FSA election change request is denied, you will have **30 days**, from the date you receive the denial, to file an appeal with FBMC. For more information, refer to the "Appeal Process" section on Page 8.

What is my Period of Coverage?

Your period of coverage for incurring expenses is your full plan year, unless you make a permitted mid-plan year election change. For a Medical Expense FSA, a mid-plan year election change will result in split periods of coverage, creating more than one period of coverage within a plan year with expenses reimbursed from the appropriate period of coverage. Money from a previous period of coverage can be combined with the new amounts anticipated after a permitted mid-plan year election change. However, expenses incurred before the permitted election change can only be reimbursed from the amount of the balance present in the Medical Expense FSA prior to the change. Mid-plan year election changes are approved only if the extenuating circumstances and supporting documentation are within your employer's Medical Expense FSA plan and the IRS regulations governing the plan.

Split periods of coverage do not apply to Dependent Care FSAs.

What are the IRS Special Consistency Rules governing Changes in Status?

1. **Loss of Dependent Eligibility**– If a change in your marital or employment status involves a decrease or cessation of your spouse's or dependent's eligibility requirements for coverage due to: your divorce, or annulment from your spouse, your spouse's or dependent's death or a dependent ceasing to satisfy eligibility requirements, you may decrease or cancel coverage only for the individual involved. You cannot decrease or cancel any other individual's coverage under these circumstances.
2. **Gain of Coverage Eligibility Under Another Employer's Plan**– If you, your spouse or your dependent gains eligibility for coverage under another employer's plan as a result of a change in marital or employment status, you may cease or decrease that individual's coverage if that individual gains coverage, or has coverage increased under the other employer's plan.
3. **Dependent Care Expenses**– You may change or terminate your Dependent Care FSA election when a Change in Status (CIS) event affects (i) eligibility for coverage under an employer's plan, or (ii) eligibility of dependent care expenses for the tax exclusion available under IRC § 129.
4. **Group-term Life Insurance, Dismemberment or Disability Coverage**– For any valid CIS event, you may elect either to increase or decrease these types of coverage.

Changing Your Coverage

Continued

Changes in Status:	
Marital Status	A change in marital status includes marriage, death of a spouse, divorce or annulment (legal separation is not recognized in all states).
Change in Number of Tax Dependents	A change in number of dependents includes the following: birth, death, adoption and placement for adoption. You can add existing dependents not previously enrolled whenever a dependent gains eligibility as a result of a valid CIS event.
Change in Status of Employment Affecting Coverage Eligibility	Change in employment status of the employee, or a spouse or dependent of the employee, that affects the individual's eligibility under an employer's plan includes commencement or termination of employment.
Gain or Loss of Dependents' Eligibility Status	An event that causes an employee's dependent to satisfy or cease to satisfy coverage requirements under an employer's plan may include change in age, student, marital, employment or tax dependent status.
Change in Residence*	A change in the place of residence of the employee, spouse or dependent that affects eligibility to be covered under an employer's plan includes moving out of an HMO service area.

Some Other Permitted Changes	
Coverage and Cost Changes*	Your employer's plans may permit election changes due to cost or coverage changes. You may make a corresponding election change to your Dependent Care FSA benefit whenever you actually switch dependent care providers. However, if a relative (who is related by blood or marriage) provides custodial care for your eligible dependent, you cannot change your salary reduction amount solely on a desire to increase or decrease the amount being paid to that relative.
Open Enrollment Under Other Employer's Plan*	You may make an election change when your spouse or dependent makes an Open Enrollment Change in coverage under their employer's plan if they participate in their employer's plan and: • the other employer's plan has a different period of coverage (usually a plan year) or • the other employer's plan permits mid-plan year election changes under this event.
Judgment/Decree/Order†	If a judgment, decree or order from a divorce, legal separation (if recognized by state law), annulment or change in legal custody requires that you provide accident or health coverage for your dependent child (including a foster child who is your dependent), you may change your election to provide coverage for the dependent child. If the order requires that another individual (including your spouse and former spouse) covers the dependent child and provides coverage under that individual's plan, you may change your election to revoke coverage only for that dependent child and only if the other individual actually provides the coverage.
Medicare/Medicaid†	Gain or loss of Medicare/Medicaid coverage may trigger a permitted election change.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	If your employer's group health plan(s) are subject to HIPAA's special enrollment provision, the IRS regulations regarding HIPAA's special enrollment rights provide that an IRC § 125 cafeteria plan may permit you to change a salary reduction election to pay for the extra cost for group health coverage, on a pre-tax basis, effective retroactive to the date of the CIS event, if you enroll your new dependent within 30 days of one of the following CIS events: birth, adoption or placement for adoption. Note that a Medical Expense FSA is not subject to HIPAA's special enrollment provisions if it is funded solely by employee contributions.
Family and Medical Leave Act (FMLA) Leave of Absence	Election changes may be made under the special rules relating to changes in elections by employees taking FMLA leave. Contact your employer for additional information.

* Does not apply to a Medical Expense FSA plan.
† Does not apply to a Dependent Care FSA plan.

COBRA Q&A

Important Continuation Coverage Information

IMPORTANT INFORMATION ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS

What is continuation coverage?

Federal law requires that most group health plans, including Medical Flexible Spending Accounts (Medical Expense FSAs), give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. "Qualified beneficiaries" can include the employee covered under the group health plan, a covered employee's spouse and dependent children of the covered employee.

Each qualified beneficiary who elects continuation coverage will have the same rights under the plan as other participants or beneficiaries covered under the plan, including special enrollment rights. Specific information describing continuation coverage can be found in the summary plan description (SPD), which can be obtained from the Public Employees Insurance Agency (PEIA).

How long will continuation coverage last?

For Group Health Plans (Except Medical Expense FSAs):

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage may be continued for up to 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's enrollment in Medicare or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to 36 months.

Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time, if a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary, if a covered employee enrolls in Medicare, or if the employer ceases to provide any group health plan for its employees. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

For Medical Expense FSAs:

You may continue your Medical Expense FSA (on a post-tax basis) only for the remainder of the plan year in which your qualifying event occurs, **if** you have not already received, as reimbursement, the maximum benefit available under the Medical Expense FSA for the year. For example, if you elected a Medical Expense FSA benefit of $1,000 for the plan year and have received only $200 in reimbursement, you may continue your Medical Expense FSA for the remainder of the plan year or until such time that you receive the maximum Medical Expense FSA benefit of $1,000.

How can you extend the length of continuation coverage?

For Group Health Plans (Except Medical Expense FSAs):

If you elect continuation coverage, an extension of the maximum period of 18 months of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify you employer of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries are disabled. The Social Security Administration (SSA) must determine that the qualified beneficiary was disabled at some time during the first 60 days of continuation coverage, and you must notify your employer of that fact within 60 days of the SSA's determination and before the end of the first 18 months of continuation coverage. All qualified beneficiaries who have elected continuation coverage and qualify will be entitled to the 11-month disability extension. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify your employer of that fact within 30 days of SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage, resulting in a maximum amount of continuation coverage of 36 months. Such second qualifying events include the death of a covered employee, divorce or separation from the covered employee or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. You must notify FBMC within 60 days after a second qualifying event occurs.

How can you elect continuation coverage?

Each qualified beneficiary has an independent right to elect continuation coverage. For example, both the employee and the employee's spouse, or only one of them, may elect continuation coverage. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the COBRA Election Form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

You should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. This amount may not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150 percent). For Medical Expense FSAs, the cost for continuation of coverage is a monthly amount calculated and based on the amount you were paying via pre-tax salary reductions before the qualifying event.

COBRA Q&A

Continued

When and how must payments for continuation coverage be made?

First Payment for Continuation Coverage

If you elect continuation coverage, you do not have to send any payment for continuation coverage with the COBRA Election Form. However, you must make your first payment for continuation coverage **within 45 days after the date of your election.** (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage within that 45 days, you will lose all continuation coverage rights under the Plan.

Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact FBMC to confirm the correct amount of your first payment. Instructions for sending your first payment for continuation coverage will be shown on your COBRA Election Notice/Form.

Periodic Payments for Continuation Coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due on the **first day of each month.** Instructions for sending your periodic payments for continuation coverage will be shown on your COBRA Election Notice/Form.

Grace Periods for Periodic Payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you pay a periodic payment later than its due date but during its grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

Keep Your Address Updated

In order to protect your family's rights, you should keep your employer and FBMC informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your employer and FBMC.

Can you elect other health coverage besides continuation coverage?

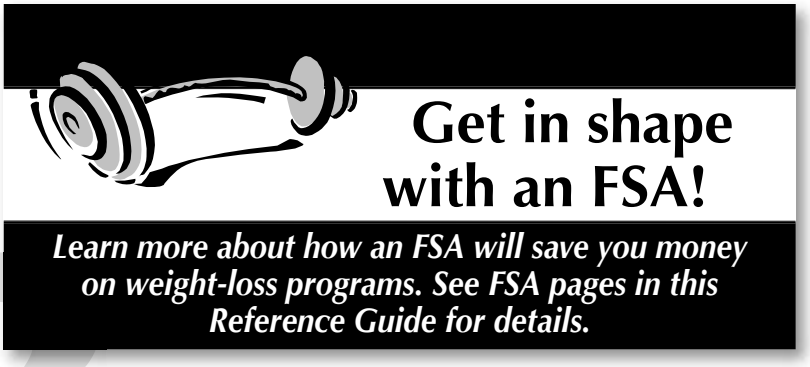
If you are retiring, you may have the right to elect alternative retiree group health coverage instead of the COBRA continuation coverage described in this Notice. If you elect this alternative coverage, you will lose all rights to the COBRA continuation coverage described in the COBRA Notice. You should also note that if you enroll in the alternative group health coverage, you lose your right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when your alternative group health coverage ends. You must contact your employer if you wish to elect alternative coverage.

If your group health plan offers conversion privileges, you have the right, when your group health coverage ends, to enroll in an individual health insurance policy, without providing proof of insurability. The benefits provided under such an individual conversion policy may not be identical to those provided under the Plan. You may exercise this right in lieu of electing COBRA continuation coverage, or you may exercise this right after you have received the maximum COBRA continuation coverage available to you. You should note that if you enroll in an individual conversion policy, you lose your right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when your conversion policy coverage ends.

For More Information

This COBRA Q&A section does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available from your employer. You can get a copy of your summary plan description from the Public Employees Insurance Agency (PEIA).

For more information about your COBRA rights, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site at **www.dol.gov/ebsa.**



Deferred Compensation (457 Plan)

Participating in the Flexible Benefits Plan may affect an employee's maximum annual contribution to the 457 plan. That is, Flexible Benefits Plan contributions reduce includible compensation* from which the maximum deferrable amount is computed. Employees should contact the Deferred Compensation vendor or the Tax Deferred Annuity (TDA) Provider about the specific effect of the Flexible Benefits Plan.

* Includible compensation is the gross income shown on your W-2 form.

Taxable Benefits and the IRS

Disability Income Protection – Disability benefits may be taxed when an employee becomes disabled depending on how the premiums were paid during the year of the disabling event. For example, if you purchased disability coverage with pre-tax premiums and/or nontaxable employer credits, any disability payments received under the plan will be subject to federal income and employment (FICA) tax. If premiums were paid with a combination of pre-tax and after-tax dollars, then any disability payments received under the plan will be taxed on a pro rata basis. If premiums were paid on a post-tax basis and a disability entitles you to receive payments, you will not be taxed on the money you receive from the plan. You can elect to have federal income tax withheld by the provider just as it is withheld from your wages. Consult your personal tax advisor for additional information.

In addition, FICA and Medicare taxes will be withheld from any disability payments paid through six calendar months following the last calendar month in which you worked prior to becoming disabled. Thereafter no FICA or Medicare tax will be withheld.

Disclaimer - Health Insurance Benefits Provided Under Health Insurance Plan(s)

Health Insurance benefits will be provided, not by your Employer's Flexible Benefits Plan, but by the Health Insurance Plan(s). The types and amounts of health insurance benefits available under the Health Insurance Plan(s), the requirements for participating in the Health Insurance Plan(s), and the other terms and conditions of coverage and benefits of the Health Insurance Plan(s) are set forth from time to time in the Health Insurance Plan(s). All claims to receive benefits under the Health Insurance Plan(s) shall be subject to and governed by the terms and conditions of the Health Insurance Plan(s) and the rules, regulations, policies, and procedures from time to time adopted.

Social Security

Social Security consists of two tax components: the FICA or OASDI component (the tax for old-age, survivors' and disability insurance) and the Medicare component. A separate maximum wage to which the tax is assessed applies to both tax components. There is no maximum taxable annual wage for Medicare. The maximum taxable annual wage for FICA is subject to federal regulatory change. If your annual salary after salary reduction is below the maximum wage cap for FICA, you are reducing the amount of taxes you pay and your Social Security benefits may be reduced at retirement time.

However, the tax savings realized through the Flexible Benefits Plan generally outweigh the Social Security reduction. Call FBMC Customer Service at 1-800-342-8017 for an approximation.

FBMC Privacy Notice 4/14/03

This notice applies to products administered by Fringe Benefits Management Company and its wholly-owned subsidiaries (collectively "FBMC"). FBMC takes your privacy very seriously. As a provider of products and services that involve compiling personal—and sometimes, sensitive—information, protecting the confidentiality of that information has been, and will continue to be, a top priority of FBMC. This notice explains how FBMC handles and protects the personal information we collect. Please note that the information we collect and the extent to which we use it will vary depending on the product or service involved. In many cases, we may not collect all of the types of information noted below. FBMC's privacy policy is as follows:

I. We collect only the customer information necessary to consistently deliver responsive services. FBMC collects information that helps serve your needs, provide high standards of customer service and fulfill legal and regulatory requirements. The sources and types of information collected generally varies depending on the products or services you request and may include:
   - Information provided on enrollment and related forms - for example, name, age, address, Social Security number, e-mail address, annual income, health history, marital status and spousal and beneficiary information.
   - Responses from you and others such as information relating to your employment and insurance coverage.
   - Information about your relationships with us, such as products and services purchased, transaction history, claims history and premiums.
   - Information from hospitals, doctors, laboratories and other companies about your health condition, used to process claims and prevent fraud.

II. Under HIPAA, you have certain rights with respect to your protected health information. You have rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan in care of FBMC's Privacy Officer or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

    Additional information that describes how medical information about you may be used and disclosed and how you can get access to this information is provided electronically on our Web site: **www.myFBMC.com**. You have a right to a paper copy at any time. Contact FBMC Customer Service at 1-800-342-8017.

III. We maintain safeguards to ensure information security. We are committed to preventing unauthorized access to personal information. We maintain physical, electronic and procedural safeguards for protecting personal information. We restrict access to personal information to those employees, insurance companies and service providers who need to know that information to provide products or services to you. Any employee who violates our Privacy Policy is subject to disciplinary action.

IV. We limit how, and with whom, we share customer information. We do not sell lists of our customers, and under no circumstances do we share personal health information for marketing purposes. With the following exceptions, we will not disclose your personal information without your written authorization. We may share your personal information with insurance companies with whom you are applying for coverage, or to whom you are submitting a claim. We also may disclose personal information as permitted or required by law or regulation. For example, we may disclose information to comply with an inquiry by a government agency or regulator, in response to a subpoena or to prevent fraud.

We will provide our Privacy Notice to current customers annually and whenever it changes. If you no longer have a customer relationship with us, we will still treat your information under our Privacy Policy, but we will no longer send notices to you. In this notice of our Privacy Policy, the words "you" and "customer" are used to mean any individual who obtains or has obtained an insurance, financial product or service from FBMC that is to be used primarily for personal or family purposes.

Continued

Notice of Administrator's Capacity

PLEASE READ: This notice advises insured persons of the identity and relationship among the contract administrator, the policyholder, and the insurer:

1. FBMC has been authorized by your employer to provide administrative services for the insurance plans offered herein. In some instances, FBMC may also be authorized by one or more of the insurance companies underwriting the benefits offered herein to provide certain services, including (but not limited to) marketing, underwriting, billing and collection of premiums, processing claims payments, and other services. FBMC is not the insurance company or the policyholder.
2. The policyholder is the entity to whom the insurance policy has been issued. The policyholder is identified on either the face page or schedule page of the policy or certificate.
3. The insurance companies noted herein have been selected by PEIA, and are liable for the funds to pay your insurance claims.

If FBMC is authorized to process claims for the insurance company, we will do so promptly. In the event there are delays in claims processing, you will have no greater rights to interest or other remedies against FBMC than would otherwise be afforded to you by law. FBMC is not an insurance company.

Spring 2008 Benefit Fairs

April 07

Charleston (9:00 – 2:00)
State Capitol Complex
Bldg. 7, Conference Room C

Charleston (3:00 – 7:00)
Charleston Civic Center
200 Civic Center Dr

April 08

Weirton (3:00 – 7:00)
Holiday Inn
350 Three Springs Dr

April 09

Wheeling (1:00 – 7:00)
Northern Community College
Market St

April 10

Parkersburg (3:00 -7:00)
Comfort Suites of Parkersburg
I-77 & WV 14 (exit 170) Mineral Wells

April 14

Martinsburg (3:00 – 7:00)
Holiday Inn
300 Foxcroft Ave

April 15

Romney (3:00 -7:00)
South Branch Inn
US Rt 50

April 16

Morgantown (10:00 – 1:30)
WVU Alumni Center
Durrett Hall

Morgantown (3:00 – 7:00)
Ramada Inn
I-68 Exit 1, US 119 N.

April 17

Huntington (3:00 – 7:00)
Big Sandy Superstore Arena
1 Civic Center Dr

April 21

Beckley (3:00 – 7:00)
Tamarack Conference Center-Ballroom A
One Tamarack Park

April 22

Flatwoods (3:00 – 7:00)
Days Inn
200 Sutton Lane

April 23

Fairmont (9:00 – 2:00)
Fairmount State College
1201 Locust Ave

FBMC
Premier Benefits Solutions

Contract Administrator
Fringe Benefits Management Company
P.O. Box 1878 • Tallahassee, Florida 32302-1878
Customer Service 1-800-342-8017 • 1-800-955-8771 (TDD)
www.myFBMC.com

Information contained herein does not constitute an insurance certificate or policy. Certificates will be provided to participants following the start of the plan year, if applicable.

FBMC/WV/0308

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